STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING _____ B. WING _____	C 07/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	2580 PRUDEN BOULEVARD SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/24/19 through 7/26/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:] (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least	E 004		8/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/14/2019

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E 004	Continued From page 1 annually. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Program (EPP), the facility failed to provide evidence of the required annual policy review for Emergency Preparedness. The findings included: A review of the facility's Emergency Preparedness Policy was conducted on 7/26/2019 at 3:48 p.m. with the Administrator. A request for documentation verifying the annual review of EP policy was conducted, yielding an EPP review dated 6/23/2017. There was no documentation of additional reviews/updates to the EP policy. At exit, the Regional Administrator stated, "I do not know what the previous administrator did with the annual revision. He may have thrown it away." No additional evidence verifying compliance with this regulatory requirement was provided prior to survey exit.	E 004	1. Emergency Preparedness Plan was reviewed and signed on 07/29/19. 2. All residents are at risk for this practice. 3. Education by Regional Vice President of Operations on Emergency Preparedness Plan annual policy review with Administrator. 4. Annual audit by Regional Vice President of Operations or corporate regional staff on Emergency Preparedness Plan to ensure policy is reviewed annually by Administrator. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must	E 036		8/26/19

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E 036	Continued From page 2 be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Program (EPP), the facility failed to provide evidence of the required annual policy review and testing for the Emergency Preparedness policy. The findings included: A review of the facility's Emergency	E 036	1. Emergency Preparedness Plan was reviewed with facility staff (all departments) to include a competency quiz. 2. All residents are at risk for this practice. 3. Education by Regional Vice President of Operations with Administrator on Emergency Preparedness Plan annual policy review. Administrator will educate	

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E 036	Continued From page 3 Preparedness Policy was conducted on 7/26/2019 at 3:48 p.m. with the Administrator. A request for documentation verifying the annual review and testing of EP policy was conducted, yielding an EPP review dated 6/23/2017. There was no documentation of additional reviews/updates and testing of the EP policy. At exit, the Regional Administrator stated, "I do not know what the previous administrator did with the annual revision. He may have thrown it away." No additional evidence verifying compliance with this regulatory requirement was provided prior to exit.	E 036	facility's staff on Emergency Preparedness Plan to include competency quiz on all new employees and annually with all employees. 4. Audit by Regional Vice President of Operations or Saber's Regional corporate staff to ensure Emergency Preparedness Plan policy is reviewed annually by Administrator as well as competency quizzes are being conducted annually with staff and upon hire during orientation. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/24/19 through 7/26/19. Four complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 59 resident reviews: 49 current residents and 10 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		8/26/19

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F 558	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interviews the facility staff to ensure reasonable accommodation of need and preferences for the use of a bariatric shower bed for 1 of 59 residents (Resident #100) in the survey sample. The findings included: Resident #100 was originally admitted to the facility on 10/06/18. Diagnosis for Resident #100 included but are not limited to *Morbid (severe) obesity. Resident #100's Minimum Data Set (MDS-an assessment protocol) with an Assessment Reference Date of 07/11/19 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #100 total dependent of two with bathing and toileting, extensive assistance of two with bed mobility, dressing, toilet use and personal hygiene for Activities of Daily Living (ADL) care. An interview was conducted with Resident #100 on 7/24/19 at approximately 11:30 a.m. Resident #100 stated," I have not had a shower since I've been here." The surveyor asked, "When were you admitted to the facility" she replied, "October of last year." The surveyor asked, "Do you want showers" she replied, "Yes, but the Certified Nursing Assistants (CNA's) are telling me they do not have a shower bed large enough for me and I'm afraid of the shower chair." The resident said she was "Unable to stand up or put any weight on	F 558	1. Resident no longer resides in this facility. 2. 100% audit of all residents in the facility will be conducted to identify the residents with diagnosis of obesity/morbid obesity or who require specialized equipment. 3a. Education will be conducted by DON or designee with nursing staff on identification of residents requiring special equipment for care needs and follow through. 3b. Education by SW or designee on resident's rights for all departments to include accommodation of needs and preferences. 4. Audit by Unit Managers with nursing staff 5 times a week x 12 weeks to ensure bariatric shower bed is being utilized by staff. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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my legs so they use the lift to transfer me." The resident stated, "I hope you can help me because I really want a shower but only on the shower bed."

The resident said "The staff are not even asking me if I want my showers, they just bathe me in bed." The surveyor asked, "Do you want showers?" she said, "I do but they don't have a shower bed large enough for me because of my size that is what the CNA's are telling me. The resident said "The shower chair would not work because I use a lift to get up because I cannot stand; I do not feel safe in a shower chair but want a larger shower bed so I can get a shower."

An interview was conducted with CNA #6 on 07/26/19 at approximately 12:32 p.m. The CNA stated, "I have never given Resident #100 a shower since I've been assigned to her nor have anyone ask me to help them with giving her a shower." The surveyor asked, "Should (Resident #100) receive her showers twice a week?" the CNA replied, "Yes, if there was a shower bed big enough for (Resident #100)."

On 07/26/19 at approximately 12:42 p.m., an interview was conducted with CNA #5 who stated, "I gave Resident #100 her showers when she first arrived at the facility but that was a long time ago." The CNA stated, "The shower bed is small for Resident #100." She explained once (Resident #100) is on the shower bed; it is a very close fit; we are unable to reposition her to give her a shower on the shower bed; the bed is too small for (Resident #100). The CNA stated, "I have never tried the shower chair." The surveyor asked, "Should (Resident #100) receive her showers twice a week" the CNA replied,

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"Absolutely, if she want her showers but we have to get a bigger shower bed."

The Administrator, Director of Nursing and Regional Administrator was informed of the finding during a briefing on 07/26/19 at approximately 5:15 p.m.

The Director of Nursing (DON) and the surveyor went to the shower room on the West Unit on 07/26/19 at approximately 6:10 p.m. The DON looked at the shower bed then stated, "This is a regular shower bed, (Resident #100) is not able to use shower bed, and she needs a bariatric shower bed. The DON stated the shower chair will not work for Resident #100. The surveyor asked, "Do you have a bariatric shower bed in the facility," she replied, "No."

The facility's policy titled Resident Rights and Facility Responsibilities (Revised November 2016).
-Policy: It is the facility's policy to abide by the resident rights, and to communicate these right to residents and their designated representatives in a language that they can understand.

(e). Respect and dignity. The resident has a right to be treated with respect and dignity, including but not limited to:
-Reasonable Accommodation. The right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do so would endanger the health and safety of the resident or other residents.

Definitions:
*Morbid obesity is an excess of body fat that

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F 558	Continued From page 7 threatens necessary body functions such as respiration (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition).	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/26/19

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F 584	Continued From page 8 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that facility staff failed to ensure a clean comfortable and homelike environment for 2 of 59 residents in the survey sample, Resident #12 and #56. The findings include: 1. Resident #12 was admitted to the facility on 6/6/2016 and readmitted on 7/3/17 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/26/19. Resident #12 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 7/24/19 at 2:00 p.m., an interview was conducted with Resident #12. Resident #12 had stated that she was afraid of the roaches that were in her room. Resident #12 stated that she liked to leave her bathroom light on during the night to prevent the roaches from coming into her room. Resident #12 also stated that the bathroom light helped her see around to make sure roaches were not on her bed. Resident #12 stated that on	F 584	1. Multiple pest control companies contacted 7/26/19 to obtain treatment services. 2. 100% audit of resident's rooms, service areas, kitchen, halls for cleanliness/pests and issues noted were corrected immediately to identify other residents at risk for this issue. 3a. Education by Administrator for Housekeeping Director on cleaning of resident's rooms, common areas, and follow up. 3b. Education by Housekeeping Director for housekeeping staff on maintaining all resident's room, common areas clean and as well as stored residents and staff open food items and containers. 3c. Education by Dietary Manager for dietary staff on cleaning kitchen and reporting any pests observed. 4a. Random audits of 4 rooms per hallway by Housekeeping Director of resident's room and common areas 5 times a week x 12 weeks. 4b. Audit 5 times a week x 12 weeks of the kitchen by dietary manager. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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one occasion she was woken up due to a roach crawling on her. During this interview a large roach was observed crawling out from underneath her wheelchair. Resident #12 told this writer to kill it so she didn't have to worry about the location of the roach later. Resident #12 stated, "This is what I am talking about." Resident #12 stated that she sees people spray for bugs in the hallway but that no one has ever been in her room to spray. Resident #12 stated that she didn't have enough money to have someone buy bug spray for her.

Concerns regarding roaches and an ineffective pest control program were discussed with the maintenance department.

On 7/26/19 at 5:53 p.m., these concerns were expressed with ASM (administrative staff member) #1, the Administrator. When asked if roaches in residents rooms was a clean, comfortable and homelike environment, ASM #1 agreed that it was not.

No further information was presented prior to exit.
2. Resident #56 expressed discontent with the condition of his room related to excessive food left on the floor following his meals which attracted roaches to his room.

Resident #56 was admitted to the nursing facility on 6/6/18 with diagnoses that included chronic respiratory failure, congestive heart disease, depression and anxiety.

The most recent Minimum Data Set (MDS) assessment was a quarterly dated 6/11/19 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 9 out of a

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possible score of 15 which indicated the resident was moderately impaired in the skills necessary for daily decision making. The resident was not assessed to have any mood or behavioral symptoms. The resident was coded as independent with set up only for eating.

The care plan dated as revised on 2/19/19 identified Resident #56 needed help with Activities of Daily Living (ADL) and was palliative care. The care plan indicated that the resident would receive the necessary ADL assistance from staff. The care plan also indicated the goal set by the staff was to ensure measures were provided to promote emotional support, anticipate and meet the resident's needs.

The following observations were made of Resident #56 in his room:

On 7/26/19 at approximately 11:00 a.m., Resident #56 was sitting on the side of the bed when he summoned this surveyor to his room. He stated, "This food has been on the floor since after I ate my breakfast. I drop the food on the floor, but they never clean it up until later."

On 7/26/19 at approximately 12:30 p.m., accompanied by the Director of Maintenance, Resident #56 was actively eating his lunch. The resident's hands were observed excessively shaking while eating, at which time food items were spilled on the floor. The resident stated, "See all this cornbread crumbs, it will stay there for a long while before the clean it up. It draws bugs to my room. I am able to trap a cockroach in this popcorn bag because they take too long to clean up the food I drop on the floor. I can't help it!" The popcorn bag was taped up with the roach

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F 584	Continued From page 11 inside and placed in another plastic bag. The bag was retrieved to later show the Administrator. The resident stated he did not keep food in his drawers or wardrobe, which was verified through inspection of these areas by this surveyor and the resident. On 7/26/19 at approximately 5:20 p.m., during debriefing, the aforementioned observations were shared with the Administrator, the Interim Director of Nursing (IDON) and the Regional Administrator. The IDON stated the resident was able to make needs known and was reliable in the information given to staff. The Administrator stated she expected rooms that required more attention be cleaned as often as needed especially soon after meals for resident satisfaction, comfort and to minimize attraction of bugs. The facility's policy and procedure titled Resident Rights and Facility Responsibilities dated 11/2016 indicated "the resident had the right to a safe, clean, comfortable homelike environment...The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior."	F 584		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	F 622		8/26/19

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(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer

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or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on resident record review, staff interviews

1. Resident #112, #74, #89, #101 have

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F 622	Continued From page 14 and facility document review the facility staff failed to ensure that comprehensive care plan goals were sent upon transfer to the hospital for 4 of 59 Residents in the survey sample, Resident #89, #112, #74 and #101. The findings included: 1. Resident #89 was a 53 year old who was initially admitted to the facility on 12/28/18 with diagnoses to include but not limited to Congestive Heart Failure and Chronic Respiratory Failure. The most recent comprehensive Minimum Data Set (MDS) is an Admission 5 Day with an Assessment Reference Date of 1/4/19. The Brief Interview for Mental Status (BIMS) indicates that Resident #89 has short and long term memory recall and is severely impaired in cognitive skills for daily decision making. The facility Discharge Report dated 1/1/19 through 5/31/19 for Resident #89 was reviewed and is documented in part, as follows: Hospital: 1/29/19 Hospital: 2/14/19 Hospital: 2/25/19 Hospital: 3/27/19 Hospital: 4/25/19 Hospital: 5/29/19 On 07/26/19 at 1:05 PM an interview was conducted with the Director of Nursing regarding Resident #89's six discharges to the hospital this year. The Director of Nursing was asked if the Resident #89's comprehensive care plan goals were sent upon discharge to the hospital. The Director of Nursing stated, "Out of the 6	F 622	had no discharges/transfers to the hospital since dates cited in 2567. 2. Audit of residents discharged in the last 30 days to identify other residents at risk. 3. Education will be conducted by DON or designee to licensed nursing staff on proper transfer/discharge protocol and complete documentation of transfer and/or discharge residents to include: contact information of Medical Director and resident representative, advanced directives, special instructions/precautions, comprehensive care plan, medical director orders, bed hold policy, transfer form. 4. Audit by DON daily 5 times a week x 12 weeks for all transfers/discharged residents to ensure proper discharge protocol is followed with complete documentation. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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discharges to the hospital 4 of them the care plan and the bedhold was not sent. We sent it on the 2/14/19 and the 4/24/19 discharge. When a resident is going out we put all the transfer papers in the Acute Care Transfer envelope and we write in that we sent the care plan and the bedhold notice. Then we tear off the top copy of the checklist and scan it into the resident's medical record. We just started doing this around April."

Resident #89's Comprehensive Care Plan last reviewed 7/9/19 contained 14 person-centered focus areas with goals and interventions included.

On 7/26/19 the Administrator was asked for the facility policy for sending the comprehensive care plan upon resident discharge. The Administrator stated that she was unable to locate a policy.

On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared.

Prior to exit no further information was shared.

2. Resident #112 was a 75 year old that was admitted to the facility on 6/14/19 with diagnoses to include but not limited to Diabetes Mellitus and Orthopedic Aftercare following surgical amputation.

Resident #112's most recent comprehensive Minimum Data Set (MDS) was an Admission assessment with an Assessment Reference Date (ARD) of 6/21/19. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible

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indicating the resident was cognitively intact and capable of daily decision making. Resident #112's MDS history was also reviewed and is documented in part, as follows:

7/4/19- Discharge Assessment-Return Not Anticipated, Unplanned.

Resident #112's Nursing Note dated 7/4/19 was reviewed and is documented in part, as follows:

Patient complained of dark stool. Fecal test X 3 all positive for blood per Name (Nurse Practitioner) send to the ER (emergency room) for evaluation and treatment.

On 07/26/19 at 1:05 PM an interview was conducted with the Director of Nursing regarding Resident #112's discharge to the hospital on 7/4/19. The Director of Nursing was asked if the Resident #112's comprehensive care plan goals were sent upon discharge to the hospital. The Director of Nursing stated, "I can not find the transfer form or any documentation to show that it was sent with the resident. When a resident is going out we put all the transfer papers in the Acute Care Transfer envelope and we write in that we sent the care plan and the bedhold notice. Then we tear off the top copy of the checklist and scan it into the resident's medical record. We just started doing this around April."

On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared.

Prior to exit no further information was shared.

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3. Resident #74 was originally admitted to the facility on 04/27/2016. The resident was discharged to the hospital on 05/02/2019 and readmitted to the facility on 05/09/2019. Diagnosis included but were not limited to, Gastrostomy and Dysphagia. Resident #74's current Minimum Data Set (MDS assessment protocol) is a quarterly assessment with an Assessment Reference Date of 06/21/2019 and was coded with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #74 as requiring extensive assistance of 1 with dressing, eating and personal hygiene, and extensive assistance of 2 with bed mobility, transfer and toilet use and total dependence of 1 with bathing.

On 07/26/2019 at approximately 12:44 p.m., the Assistant Director of Nursing (ADON) was asked, "Can you provide documentation that the comprehensive care plan goals were sent with Resident #74 upon discharge to the hospital on 05/02/2019?" The ADON was unable to provide documentation evidencing that Resident #74's comprehensive care plan goals were sent upon discharge to the hospital. The ADON stated, "There are a lot of holes in the process, it's hit or miss if they are sending out the Bed Hold Notices and care plan goals when the residents are sent to the hospital. I was just made aware 6 weeks ago that the bed hold notice was to be sent when the resident is sent to the hospital." The ADON was asked, "What are your expectations of the nurses when residents are sent to the hospital?" The ADON stated, "I expect the nurses to send the Bed Hold Notice and care plan goals to the hospital. The nurses are suppose to document on

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the Interact checklist the information sent with the resident upon discharge to the hospital. I had also expected the nurses to document in the nurse note when they sent the bed hold notice and care plan goals. I've been told that the nurses are going to be able to scan the Interact note into the resident record."

The Administrator, Assistant Director of Nursing and Regional Administration were made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the finding.

4. Resident #101 was admitted to the facility on 8/20/19 and readmitted on 6/28/19 with diagnoses that included but were not limited to repeated falls, fracture of left hip, and high blood pressure. Resident #101's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 7/5/19. Resident #101 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #101's clinical record revealed that she had been sent out to the hospital on 6/24/19. The following note was documented: "Patient was found by house keeping laying on the floor on her right (sic) hip on top of her roommates fall mat. Patient states I think my hip left is broken...I was given an order to send out 911. Patient was not removed from the floor pillows only to support until 911 arrived."

There was no evidence that the required documentation: physician contact information, resident representative contact information, special instructions for ongoing care, advance

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directives and comprehensive care plan goals were sent with the resident upon transfer to the hospital on 6/24/19.

On 7/26/19 at 12:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #8. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #8 stated that nurses send the acute care transfer summary, SBAR (situation, background, Assessment and recommendation form), medication list, and any pertinent labs. When asked if care plan goals were sent with the resident upon transfer to the hospital, LPN #8 stated, "I have not." LPN #8 also stated that the nurses did not send out bed hold notification.

On 7/26/19 at 12:32 p.m., an interview was conducted with LPN #1 the unit manager. She could not find evidence that the required information was sent with Resident #101 upon transfer to the hospital.

On 7/26/19 at 12:39 p.m., an interview was conducted with ASM (administrative staff member) #2, the ADON (Assistant Director of Nursing) and interim DON (Director of Nursing). ASM #2 sat down with this writer while she looked for the above documentation. ASM #2 could not find the required items for discharge. ASM #2 stated that the nurses were supposed to send all the required items with the resident upon transfer to the hospital.

On 7/26/19 at 5:53 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the Administrator, the ADON and interim DON. ASM #1 stated they did not have a policy regarding the above concerns. No further

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F 622	Continued From page 20 information was presented prior to exit.	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review the facility staff failed to ensure that the bed hold policy was provided to the resident or resident representative upon	F 625	1.Residents #112, #74, #89, #101, #1 have not had any further discharges/transfers to the hospital since dates cited in 2567. Resident #461 did not	8/26/19

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F 625	Continued From page 21 transfer to the hospital for 6 of 59 Residents in the survey sample, Resident #89, #112, #74, #1, #101 and #461. The findings included: 1. Resident #89 was a 53 year old who was initially admitted to the facility on 12/28/18 with diagnoses to include but not limited to Congestive Heart Failure and Chronic Respiratory Failure. The most recent comprehensive Minimum Data Set (MDS) is an Admission 5 Day with an Assessment Reference Date of 1/4/19. The Brief Interview for Mental Status (BIMS) indicated that Resident #89 has short and long term memory recall and is severely impaired in cognitive skills for daily decision making. Resident #89 MDS history was reviewed and is documented in part, as follows: 1/29/19- Discharge Assessment-Return Anticipated, Unplanned. 2/4/19- Re-Entry from Acute Hospital. 2/14/19-Discharge Assessment-Return Anticipated, Unplanned. 2/18/19- Re-Entry from Acute Hospital. 2/25/19-Discharge Assessment-Return Anticipated, Unplanned. 3/2/19- Re-Entry from Acute Hospital. 5/29/19-Discharge Assessment-Return Anticipated, Unplanned. 6/6/19 Re-Entry from Acute Hospital. The facility Discharge Report dated 1/1/19 through 5/31/19 for Resident #89 was reviewed and is documented in part, as follows:	F 625	return to this facility after date cited on 2567. 2. Audit of residents discharged in the last 30 days to identify residents at risk for this issue 3. Education will be conducted by DON or designee for licensed nursing staff on proper transfer/discharge protocol and complete documentation of transfer and/or discharged residents to include: contact information for Medical Director and resident representative, advance directives, special instructions/precautions, comprehensive care plan, Medical director orders, bed hold policy and transfer form. 4. Audit by DON daily 5 times a week x 12 weeks on all transferred residents to ensure bed hold policy and care plans were sent upon departure from the facility. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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Hospital: 1/29/19
Hospital: 2/14/19
Hospital: 2/25/19
Hospital: 3/27/19
Hospital: 4/25/19
Hospital: 5/29/19

On 07/26/19 at 1:05 PM an interview was conducted with the Director of Nursing regarding Resident #89's six discharges to the hospital this year. The Director of Nursing was asked if the facility bedhold policy was sent upon discharges to the hospital for Resident #89. The Director of Nursing stated, "Out of the 6 discharges to the hospital 4 of them the care plan and the bedhold was not sent. We sent it on the 2/14/19 and the 4/24/19 discharge. When a resident is going out we put all the transfer papers in the Acute Care Transfer envelope and we write in that we sent the care plan and the bedhold notice. Then we tear off the top copy of the checklist and scan it into the resident's medical record. We just started doing this around April."

On 7/26/19 the Administrator was asked for the facility policy for sending the Bedhold Policy upon resident discharge. The Administrator stated that she was unable to locate a policy.

On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared.

Prior to exit no further information was shared.

2. Resident #112 is a 75 year old that was admitted to the facility on 6/14/19 with diagnoses

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to include but not limited to Diabetes Mellitus and Orthopedic Aftercare following surgical amputation.

Resident #112's most recent comprehensive Minimum Data Set (MDS) was an Admission assessment with an Assessment Reference Date (ARD) of 6/21/19. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #112's MDS history was also reviewed and is documented in part, as follows:

7/4/19-Discharge Assessment-Return Not Anticipated, Unplanned.

Resident #112's Nursing Note dated 7/4/19 was reviewed and is documented in part, as follows: Patient complained of dark stool. Fecal test X 3 all positive for blood per Name (Nurse Practitioner) send to the ER (emergency room) for evaluation and treatment.

On 07/26/19 at 1:05 PM an interview was conducted with the Director of Nursing regarding Resident #112's discharge to the hospital on 7/4/19. The Director of Nursing was asked if a Bedhold Policy was sent upon discharge to the hospital for Resident #112. The Director of Nursing stated, "I can not find the Transfer Form or any documentation to show that it was sent with the resident. When a resident is going out we put all the transfer papers in the Acute Care Transfer envelope and we write in that we sent the care plan and the bedhold notice. Then we tear off the top copy of the checklist and scan it into the resident's medical record. We just started doing this around April."

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On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared.

Prior to exit no further information was shared.

3. Resident #74 was originally admitted to the facility on 04/27/2016. The resident was discharged to the hospital on 05/02/2019 and readmitted to the facility on 05/09/2019. Diagnosis included but were not limited to, Gastrostomy and Dysphagia. Resident #74's current Minimum Data Set (MDS assessment protocol) is a quarterly assessment with an Assessment Reference Date of 06/21/2019 and was coded with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment.

On 07/26/2019 at approximately 12:44 p.m., the Assistant Director of Nursing (ADON) was asked, "Can you provide documentation that the written Bed Hold Policy was sent with Resident #74 upon discharge to the hospital on 05/02/2019?" The ADON was unable to provide documentation evidencing that the written Bed Hold Policy was sent upon discharge to the hospital. The ADON stated, "There are a lot of holes in the process, it's hit or miss if they are sending out the bed hold notices and care plan goals when the residents are sent to the hospital. I was just made aware 6 weeks ago that the Bed Hold Notice was to be sent when the resident is sent to the hospital." The ADON was asked, "What are your expectations of the nurses when residents are sent to the hospital?" The ADON stated, "I

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expect the nurses to send the bed hold notice and care plan goals to the hospital. The nurses are suppose to document on the Interact checklist the information sent with the resident upon discharge to the hospital. I had also expected the nurses to document in the nurse note when they sent the bed hold notice and care plan goals. I've been told that the nurses are going to be able to scan the Interact note into the resident record."

The Administrator, Assistant Director of Nursing and Regional Administration was made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the finding.

4. Resident #1 was admitted to the facility originally on 03/15/2019. The resident was discharged to the community on 04/05/2019, readmitted to the facility on 07/10/2019, discharged to the hospital on 07/11/2019 and readmitted to the facility on 07/22/2019. Diagnosis included but were not limited to, Chronic Kidney Disease and Acute Respiratory Failure. Resident #1's Minimum Data Set (MD-an assessment protocol) with an Assessment Reference Date of 03/22/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 06 indicating severe cognitive impairment.

On 07/26/2019 at approximately 12:44 p.m., the Assistant Director of Nursing (ADON) was asked, "Can you provide documentation that the written Bed Hold Policy was sent with Resident #1 upon discharge to the hospital on 07/11/2019?" The ADON was unable to provide documentation evidencing that the written bed hold policy was sent upon discharge to the hospital. The ADON

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stated, "There are a lot of holes in the process, it's hit or miss if they are sending out the bed hold notices and care plan goals when the residents are sent to the hospital. I was just made aware 6 weeks ago that the bed hold notice was to be sent when the resident is sent to the hospital." The ADON was asked, "What are your expectations of the Nurses when residents are sent to the hospital?" The ADON stated, "I expect the nurses to send the bed hold notice and care plan goals to the hospital. The nurses are suppose to document on the Interact checklist the information sent with the resident upon discharge to the hospital. I had also expected the nurses to document in the nurse note when they sent the bed hold notice and care plan goals. I've been told that the nurses are going to be able to scan the Interact note into the resident record."

The Administrator, Assistant Director of Nursing and Regional Administration was made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the finding.

5. Resident #101 was readmitted to the facility on 6/28/19 with diagnoses that included but were not limited to repeated falls, fracture of left hip, and high blood pressure. Resident #101's most recent MDS (Minimum Data Set) assessment was a significant change assessment with an ARD (assessment reference date) of 7/5/19. Resident #101 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #101's clinical record revealed that she had been sent out to the

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hospital on 6/24/19. Further review of Resident #101's clinical record revealed that she was admitted back to the facility on 6/28/19 with a diagnosis of a left hip fracture that required surgical repair.

There was no evidence that the written bed hold notification was sent with the resident upon transfer to the hospital on 6/24/19.

On 7/26/19 at 12:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #8. When asked what documents were sent with residents for an acute care transfer to the hospital, LPN #8 stated that nurses send the acute care transfer summary, SBAR (situation, background, assessment and recommendation form), medication list, and any pertinent labs. LPN #8 also stated that the nurses did not send out bed hold notification.

On 7/26/19 at 12:32 p.m., an interview was conducted with LPN #1 the unit manager. She could not find evidence that the bed hold notice was sent with Resident #101 upon transfer to the hospital.

On 7/26/19 at 12:39 p.m., an interview was conducted with ASM (administrative staff member) #2, the ADON (Assistant Director of Nursing) and interim DON (Director of Nursing). ASM #2 sat down with this writer while she looked for the bed hold notice. ASM #2 could not find the bed hold notice. ASM #2 stated that the nurses were supposed to send the written bed hold with the residents notice upon transfer to the hospital.

On 7/26/19 at 5:53 p.m., the above concerns were addressed with ASM (administrative staff

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member) #1, the Administrator and ASM #2 the ADON and interim DON. No further information was presented prior to exit. ASM #1 stated that they did not have a policy regarding bed holds.

6. Resident #461 was admitted to the facility on 9/1/17 with diagnoses that included but were not limited to high blood pressure, unspecified dementia, restlessness and agitation, schizophrenia, and Alzheimer's disease. Resident #461's most recent comprehensive MDS (Minimum Data Set) assessment was an admission assessment with an ARD (assessment reference date) of 9/8/17. Resident #461 was coded as being severely impaired in cognitive function scoring nine out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #461 was coded in Section E (Behaviors) as having wandering behaviors.

Review of Resident #461's clinical record revealed that he was sent out to the hospital on 10/25/17. Further review of Resident #461's clinical record revealed that he went to the ER (emergency room) and was discharged to (The name of Mental Health). There was no evidence that the facility refused to take him back once he was stable.

There was no evidence that written bed hold notification was given to Resident #461 upon transfer to the hospital.

On 7/26/19 at 1:04 p.m., an interview was conducted with OSM #1 the previous social worker at the time of the above incident. OSM #1 stated that Resident #461 had aggressive behaviors and also wandered. OSM #1 stated that she would get pressure all the time from

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F 625	Continued From page 29 administrative staff to discharge Resident #461 or to have the daughter come and get him. OSM #4 stated that the facility had refused Resident #461 to come back to the facility after he was stable at the (Name of Mental Health center). When asked if a bed hold was issued to Resident #461 at the time of his transfer, OSM #4 stated, "It sure wasn't." When asked why a bed hold policy was not offered to Resident #461, OSM #4 stated that administration did not want the resident back. On 7/26/19 at 1:56 p.m., an interview was conducted with OSM #2, the admission coordinator from the mental health facility. He could not find any evidence that the facility refused Resident #461. OSM #2 stated that Resident #461 was admitted to a different facility after his stay at the center. Complaint Deficiency.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review the facility staff failed to complete each required section of an MDS (Minimum Data Set) assessment for 1 out of 59 residents (Resident #41) in the survey sample. The findings included: The facility staff failed to complete the required	F 641	1. New MDS assessment completed for resident #41 to include section C. 2. 100% audit of residents with MDS assessments completed in the past 30 days to ensure accuracy of all sections to identify residents at risk for this issue. 3. Education by Regional MDS nurse with MDS staff on accuracy of MDS assessments to reflect the resident's status.	8/26/19

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F 641	Continued From page 30 section of Resident #41's quarterly MDS: section C-Brief Interview for Mental Status. Resident #41 was admitted to the facility on 10/21/14. Diagnoses for Resident #41 included but are not limited to *Alzheimer's disease. Review of the most recent quarterly MDS with an ARD (Assessment Reference Date) of 05/31/19 revealed Section C (Cognitive Patterns) was not completed. Under (C0100) Section C, should the Brief Interview for Mental Status be conducted, the MDS was coded as Yes. Further review of section (C0100) showed evidence that Section (C0100) was not completed. Under Section C (C0600) asks if the staff assessment for mental status be conducted, the MDS was coded No. An interview was conducted with the Social Worker on 07/26/19 at approximately 3:12 p.m., who stated, "Resident #41 was unable to answer the questions under section C." She said Resident #41's cognition is impaired so the nursing staff should have been interviewed. The surveyor asked, "Is this an accurate MDS assessment" she replied, "No." On 07/26/19 at approximately 4:39 p.m., an interview was conducted with the MDS Coordinator who stated, "If a resident is not interviewable then the staff should have been interviewed." She said we use the RAI manual as our guide to ensure an accurate resident assessment. The Administrator, Director of Nursing and Regional Administrator was informed of the finding during a briefing on 07/26/19 at approximately 5:15 p.m. The facility did not present any further information about the findings.	F 641	4. Audit by DON 5 times a week x 12 weeks on all residents with MDS assessments to ensure MDS accuracy. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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F 641	Continued From page 31 Definitions: *Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm). CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI) 1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status. Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-	F 655		8/26/19

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F 655	Continued From page 32 (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and documentation review, it was determined that facility staff failed to complete and implement a baseline care plan within 48 hours of admission	F 655	1. Residents #27, #66, #92 remain in the facility and care plans are current and being implemented. 2. 100% audit of all residents admitted	

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F 655	Continued From page 33 for three of 59 residents (Resident #27, #66 and #92) in the survey sample. The findings include: 1. Resident #27 was admitted to the nursing facility on 12/15/2018. Diagnoses included but not limited to, End Stage Renal Disease and Muscle Weakness. The current Minimum Data Set (MDS) a quarterly revision MDS with an Assessment Reference Date (ARD) of 05/07/19 coded the resident with a 14 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated that Resident #27's cognitive abilities for daily decision making were intact. A Review of the MDS (Minimum Data Set) Section A, A1600-Entry Date of 12/15/18. Section A, A1700 Reads: Type of Entry: Admission. A review of the Resident #27's Baseline care plan in the clinical record read the following: Most Recent admission: 12/15/18. Date Resident/Resident Representative explained and received: 12/19/18. On 07/24/19 at approximately 12:55 PM, an interview was conducted with the Resident's spouse (Resident Representative) and was asked if she had received a copy of resident's Baseline Care Plan? She stated, "No." On 07/26/19 at approximately 6:47 PM an interview was conducted with the Social Worker (Other Staff #5) She was asked if there was any other written documentation concerning the Resident Representatives or the above Resident	F 655	within the last 30 days for baseline care plan to identify others at risk for this issue. 3. Education by DON or designee with MDS nurse, licensed nursing staff, and social worker on completing the baseline care plan within 48 hours of admission. 4. Audit by DON 5 times a week x 12 weeks on all new admissions to ensure baseline care plan was completed and provided to resident and/or resident's representative and documented. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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noting that they had received baseline care plans. She stated, "No."

2. Resident #66 was admitted to the nursing facility on 01/28/19. Diagnoses for included but was not limited to, Diabetes Mellitus and Hypertension.

The current Minimum Data Set (MDS) a quarterly Revision MDS with an Assessment Reference Date (ARD) of 06/19/19 coded the resident with a 10 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The section A, under Identification, A1600 reads as follows: Entry Date, 02/22/2019. A1700 reads: Type of Entry: Admission.

A review of the Resident #66's Baseline care plan check list in the clinical record read the following: Most Recent admission: 02/22/19. Date Resident/Resident Representative explained and received: 03/06/19.

On 07/26/19 at approximately 6:47 PM an interview was conducted with the Social Worker (Other Staff #5) She was asked if there was any other written documentation concerning the Resident Representatives or the above Resident noting that they had received baseline care plans. She stated, "No."

3. Resident #92 was admitted to the facility on 1/08/19. Diagnoses for Resident #92 included but was not limited to Anemia and Dementia.

The current Minimum Data Set (MDS) a quarterly Revision MDS with an Assessment Reference Date (ARD) of 01/08/19 coded the resident with a

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04 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The section A, under Identification, A1600 reads as follows: Entry Date, 01/08//2019. A1700 reads: Type of Entry: Admission.

A review of the Resident #92's Baseline care plan in the clinical record reads the following: Most Recent admission: 01/08/19. Date Resident/Resident Representative explained and received: 01/14/19.

An interview was conducted with the Social Worker (Other Staff #5, concerning Baseline Care Plan time frames. She said "They must be done within 5 days." She was asked to read line #7 on the Baseline Care Plan checklist listed in the clinical record. She then stated "It's 48 hours." She was then asked what should have been done? She stated "We fill them out and give them to the residents within 48 hours."

On 07/26/19 at approximately 6:47 PM an interview was conducted with the Social Worker (Other Staff #5) She was asked if there was any other written documentation concerning the Resident Representatives or the above Residents noting that they had received baseline care plans. She stated, "No."

Pre-exit interview was conducted on 07/26/19 at approximately, 5:35 PM. Present were IDON (Interim Director of Nursing, Admin. #2), The Regional Administrator(Admin. #3) and Administrator (Admin #1). The IDON stated that the baseline care plan should be completed in 72 hours. The IDON returned later and stated. "The baseline care plan should be completed within 48

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F 655	Continued From page 36 hours."	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview, facility documentation review and clinical record review it was determined that facility staff failed to revise the comprehensive care plan for 4 residents (Resident #3, Resident	F 657	1. Care plan for resident #3 was revised to address the resident's need for extensive assistance of 1 for eating. Care plan for resident #74 was revised to reflect current order for water flushes of	8/26/19

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F 657	Continued From page 37 #74, #83, #31) of 59 residents in the survey sample. The findings included: 1. Resident #3 was admitted to the facility on 01/14/2019. The resident was on Hospice. Diagnosis included but were not limited to, Chronic Pain Syndrome and Osteonecrosis Left Femur. The current Minimum Data Set (MDS an assessment protocol) was a significant change in status assessment with an Assessment Reference Date of 04/12/2019. The MDS coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #3 as requiring extensive assistance of 1 for eating, dressing, toilet use and personal hygiene, extensive assistance of 2 for bed mobility and total dependence of 1 for bathing. On 07/25/2019 Resident #3's comprehensive care plan was reviewed and it was documented that the resident was independent with eating, set up. The comprehensive care plan did not include that the resident required extensive assistance of 1 staff person for eating. On 07/25/2019 at 4:20 p.m., an interview was conducted with the MDS Coordinator and she was asked, "Should Resident #3's needs with eating be reflected in his comprehensive care plan?" The MDS Coordinator stated, "Yes." The MDS Coordinator was asked, "Was the comprehensive care plan revised to reflect the residents needs with eating as indicated in the MDS?" The MDS Coordinator stated, "No, but the resident doesn't always need assistance with	F 657	300cc every 4 hours. Care plan for resident #83 was revised to address the use of a cup with an attached lid for all hot beverages. Care plan for resident #31 was revised to address the use of oxygen. 2. Audit of current residents care plans to ensure accuracy with current orders and interventions to identify other residents at risk. 3. Education by Regional MDS nurse with MDS staff on timing and revision of care plans. 4. Audit by DON weekly x 12 weeks on all care plans that were revised and ensuring all Medical Directors orders such as acute changes and falls are reflecting accurately in residents' care plans. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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eating, just at times." The MDS Coordinator was asked, "Should the comprehensive care plan reflect the resident needs with eating even if it is just at times?" The MDS Coordinator stated, "Yes, I should have care planned that the resident may need assistance with meals at times." The MDS Coordinator was asked, "What is the purpose of the comprehensive care plan?" The MDS Coordinator stated, "To communicate the resident needs to the staff."

The Administrator, Assistant Director of Nursing and Regional Administration were made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the finding.

2. Resident #74 was originally admitted to the facility on 04/27/2016. The resident was discharged to the hospital on 05/02/2019 and readmitted to the facility on 05/09/2019. Diagnoses included but were not limited to, Gastrostomy (for tube feeding) and Dysphagia. Resident #74's current Minimum Data Set (MDS assessment protocol) was a quarterly assessment with an Assessment Reference Date of 06/21/2019 and was coded with a BIMS (Brief Interview for Mental Status) score of 01 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #74 as requiring extensive assistance of 1 with dressing, eating and personal hygiene, and extensive assistance of 2 with bed mobility, transfer and toilet use and total dependence of 1 with bathing.

On 07/25/2019 Resident #74's Physician Order's was reviewed and revealed orders for "Enteral Feed Order every 4 hours 300 cc (cubic centimeter) water flush." Review of Resident

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#74's comprehensive care plan read, "Nutritional Status: (Resident name) is receiving Total Nutrition through TF (Tube Feeding). Receives Isosource 1.5 80cc/hr (hour) nocturnal feeding from 8 P.M. - 8 A.M. with 150 cc H20 (Water) Q (Every) 4 hr. NPO (Nothing By Mouth). Care plan was revised on 07/02/2019.

On 07/25/2019 at 4:15 p.m., an interview was conducted with the MDS Coordinator and reviewed the water flush discrepancies in the physician orders and the comprehensive care plan. The MDS Coordinator was asked, "Who updates the care plans?" The MDS Coordinator stated, "The MDS Coordinator." The MDS Coordinator was asked, "Was the care plan revised to reflect the physician orders?" The MDS Coordinator stated, "No, but it should have been revised to reflect the care plan." The MDS Coordinator was asked, "What is the purpose of the comprehensive care plan?" The MDS Coordinator stated, "To communicate the residents needs to the staff."

The Administrator, Assistant Director of Nursing and Regional Administration were made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the finding.

The facility's policy: Enteral Feeding Via Continuous Pump

Policy: Licensed nurses through the use of an enteral nutrition pump will administer enteral feeding when volume control is indicated and as ordered by physician.
3. The facility staff failed to revise Resident #83's care plan to include the implementation of a

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sturdy cup with a lid on it.

Resident #83 was admitted to the facility on 10/16/17 with diagnoses to include, but not limited to, schizophrenia, bipolar disorder, Alzheimer's disease and combative behaviors. The MDS (Minimum Data Set) prior to the unusual occurrence incident on 1/22/19 was a quarterly with an assessment reference date of 12/8/18. The resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired daily decision making skills.

A Facility Reportable Incident (FRI), incident type Unusual Occurrence, was received at the State Agency on 1/23/19. The FRI evidenced that on 1/22/19 Resident #74 while in her wheelchair bumped into the wheelchair of Resident #83. This resulted in Resident #83 "throwing her coffee" at Resident #74.

The five day facility follow up report to the FRI was received at the State Agency on 1/28/19. The report read in part:"...The facility will provide a sturdy cup with a lid for (Resident #83's name)...Care plans were updated on both residents..."

On 7/25/19 the Comprehensive Person-Centered Care Plan initially dated 11/2/17 did not include the revision to include a sturdy cup per the five day follow up report. The care plan was revised on 1/22/19, the intervention was to educate staff and visitors that the resident is not to receive hot beverages.

On 7/26/19 at 5:53 p.m., the MDS Coordinator who revised the care plan on 1/22/19 was

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interviewed. She stated she failed to complete the intervention which should have read, "Educate staff that resident is not to receive hot beverages unless it is in a cup with a secure lid." When asked if that was an important piece to have been left off the intervention she stated, "Yes ma'am it sure was."

During the pre-exit survey conducted on 7/26/19 the above findings was shared with the Administrator, the Interim Director of Nursing and the Regional Administrator.

4. Resident #31 was admitted to the facility on 2/4/16 with diagnoses that included but were not limited to pneumonia, muscle weakness, Alzheimer's disease and hypothyroidism. Resident #31's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with and ARD (assessment reference date) of 5/10/19. Resident #31 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #31's clinical record revealed that he was diagnosed with pneumonia on 7/20/19. The following orders were documented:
1) 02 (oxygen) continuous via NC (nasal cannula) at 2 L (liters)/min (minute) every shift.
2) Levofloxacin Tablet (Levaquin-an antibiotic) (1) Give 750 mg (milligrams) by mouth one time a day for infiltrated lower left lobe until 7/27/19."

A care plan regarding Resident #31's need for oxygen could not be found on his comprehensive care plan dated 4/4/16 and revised on 7/24/19.

On 7/26/19 at 10:47 a.m., an interview was conducted with RN (Registered Nurse) #2, the

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F 657	Continued From page 42 MDS coordinator. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was for staff to get a clear picture of the resident and to know how to care for the resident. When asked if it was important for the care plan to be accurate, RN #2 stated that it was important. When asked who was responsible for updating care plans, RN #2 stated any nurse could update the care plan but that MDS has been doing it with each quarterly assessment with any new changes. When asked if she would expect to see oxygen therapy on a care plan for a resident who was put on oxygen, RN #2 stated that she would expect to see oxygen therapy on the care plan. RN #2 confirmed that she did not see oxygen therapy on the care plan. On 7/26/19 at 5:53 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the Administrator and ASM #2 the ADON (Assistant Director of Nursing) and interim DON. No further information was presented prior to exit. Facility policy titled, "Care Plan," documents in part, the following: "V) The MDS coordinator is to review the 24 hour- report daily for significant changes or changes in resident's ADL status. The Care Planning coordinator will add minor changes in residents status to the existing care plan on daily basis."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		8/26/19

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F 658	Continued From page 43 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility documentation review, the facility staff failed to follow physician orders for blood sugar monitoring on 07/05/19 for 1 (Resident #27) of 59 residents in the survey sample. The findings include: Resident #27 was admitted to the nursing facility on 12/15//2018. Diagnosis included but not limited to Diabetes Mellitus and End Stage Renal Disease. The current Minimum Data Set (MDS) a quarterly revision MDS with an Assessment Reference Date (ARD) of 05/07/19 coded the resident with a 14 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS). This indicated Resident #27's cognitive abilities for daily decision making were intact. Section I, Metabolic,12900 of the MDS indicated that Resident #27 had Diabetes Mellitus. A review of the Medication Administration Record (MAR) for July 2019 was conducted. On 07/05/2019 at 1130 physicians order included: Novolin R solution 100 unit/ML (Insulin Regular Human) inject as per sliding scale however, no blood sugar reading was evidenced. An X was placed in the box for the blood sugar reading to include "#19" with nurse initials. On 07/26/19 at approximately 1:48 PM an interview was conducted with Licensed Practical Nurse (LPN) #6. She was asked what does #19 indicate on the MAR. She stated that #19	F 658	1. Resident #27 continues to have an order for insulin based on blood sugar results and blood sugar is being checked four times a day per the physician's order. 2. 100% audit of current residents with orders for blood sugars related to sliding scale to identify other residents at risk. 3. Education by DON or designee with licensed nursing staff on ensuring blood sugar is obtained and documented prior to administrating insulin. 4. Audit by Unit Managers 5 times a week x 12 weeks on all diabetic residents acquiring insulin to ensure all blood sugars have been obtained. Audit results will be taken to QAPI for review and revision as needed. 5. 08/26/2019	

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F 658	Continued From page 44 indicates "It means to refer to the nurses notes." A review of progress notes dated 07/05/19 read: Note Text, Novolin R Solution 100 Unit/ML. Inject as per sliding scale : If 201-250= 2 Units; 251-300 = 4 Units; 301-350 = 6 units; 351-400 = 8 Units. Notify MD for Blood Sugar (BS) over 400. Nurse noted response= Unable. On 7/26/19 at approximately 2:16 PM, LPN #6, approached surveyor stating she had the nurse on the phone to discuss Resident #27. LPN #4 was asked did documenting "unable" mean that the resident didn't receive a blood sugar check on 07/05/19 at 11:30 AM? She stated "Yes." On 07/26/19 at approximately, 5:35 PM, a pre-exit interview was conducted. Present were the Assistant Director Of Nursing (ADON), Administrative/Corporate Staff #3 and the facility Administrator. No further information was provided by the facility staff.	F 658		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced	F 687		8/26/19

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F 687	Continued From page 45 by: Based on resident interview, family member interview, staff interviews, clinical record review and facility documentation review, the facility staff failed to provide foot nail care and/or podiatry services for four of 59 residents in the survey sample (Resident #27, #66, #43 and #12). The findings include: 1. Resident #27 was admitted to the nursing facility on 12/15/2018. Diagnoses included but not limited to End Stage Renal Disease and Diabetes Mellitus. The current Minimum Data Set (MDS) a quarterly revision MDS with an Assessment Reference Date (ARD) of 05/07/19 coded the resident with a 14 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), which indicated Resident #27's cognitive abilities for daily decision making were intact. On 07/25/19 at approximately 12:44 PM an observation of Resident #27's feet was made with assistance from LPN (Licensed Practical Nurse) #9. The Resident's toenails on both feet were thick and yellow. Resident and Resident Representative (RP) was asked if he had received podiatry services since his admission. They both stated "No." On 07/25/19 at approximately 1:00 PM LPN #6 was asked for the podiatry book. She stated that the ADON (Assistant Director of Nursing) has the podiatry list. On 07/26/19 at approximately 1:27 PM an interview was conducted with CNA (Certified	F 687	1. Podiatry appointments have been scheduled for residents #27, #66, #43, and #12. 2. 100% audit of current residents to identify other residents in need of foot/podiatry care. 3. Education by DON or designee with nursing staff to identify and address those residents needing assistance with toe/nail care including documenting and reporting. 4. Random audits of 10 residents per week by Unit Managers x 12 weeks to identify residents that require nail care. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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Nursing Assistant) #8 concerning Resident #27. She was ask how do you know when a resident needs foot care. "If I wash them up and notice any dryness, if their toenails are too long, hanging over or if I see anything is abnormal, I will report it to nurse on the floor." " I'll ask if they are a diabetic. If not, I will trim their toenails." She was then asked where would you document it? "I would put it in the kiosk after I inform the nurse." She was also asked would documenting in the kiosk system alert the nurse if you forget to tell her? She states "Yes." LPN #6 was also interviewed concerning when to add residents to the podiatry list. She stated that the CNA's "Do bi-weekly skin checks during daily baths; they would let the nurse know; the nurse will assess the area." She stated "Their name is put on the podiatry list if needed."

On 07/26/19 at approximately 7:02 PM, the podiatry list was received from the DON (Director of Nursing). Resident #27's name was on the typed list. No date was added to the list.

2. The facility staff failed to provide podiatry services for Resident #66.

Resident #66 was admitted to the nursing facility on 01/28/19. Diagnosis included but not limited to Diabetes Mellitus and Hypertension.

The current Minimum Data Set (MDS) a quarterly Revision MDS with an Assessment Reference Date (ARD) of 06/19/19 coded the resident with a 10 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.

On 07/24/19 at approximately 12:20 PM. The

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Resident's feet were observed while he was lying in bed. His left great toenail was embedded into his skin. His Spouse said she informed one of the nurses a month ago.

On 07/25/19 at approximately 9:28 AM the ADON (Assistant Director of Nursing) was asked for a podiatry policy. The ADON stated their is no policy and stated "The staff will tell me and I will add their names to the list."

On 07/25/19 at approximately 11:58 AM per LPN (Licensed Practical Nurse) #6 the resident is not listed in the book to receive podiatry services.

A review of the nurse's note dated 07/26/19 at 11:52 AM stated the following: On pt. right foot, noticed nail into skin. Patient denies pain. Wife states she wants him to be seen by podiatry consult also. An appointment was made for 08/01/19 at 10:00 AM.

On 07/26/19 at approximately 11:53 AM, an interview was conducted with LPN #6. She was asked if Resident #66's feet/toenails should have been assessed sooner? She stated, "The issue should have been addressed doing skin checks."

On 07/26/19 at approximately 7:02 PM, the podiatry list was received from the DON (Director of Nursing). Resident #27's name was on the typed list. No date was added to the list.

On 07/26/19 at approximately 5:35 PM, a pre-exit interview was conducted. Present were the Assistant Director Of Nursing (ADON), Administrative/Corporate staff #3 and the facility Administrator. No comments were made concerning the above.

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3. The facility staff failed to ensure that podiatry services was provided to Resident #43. Resident #43 was admitted to the facility on 02/12/15. Diagnoses for Resident #43 included but not limited to *Dementia without behavioral disturbances.

The most recent Minimum Data Set (MDS) was a significant change assessment with an Assessment Reference Date (ARD) of 06/21/19 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 03 out of a possible score of 15, which indicated severe cognitive impairment for daily decision-making. Resident #43 was coded total dependence of two with transfer, total dependence of one with bathing, personal hygiene, toilet use, eating and dressing and extensive assistance of two with bed mobility.

Resident #43's comprehensive care plan with a revision date of 03/28/19 documented Resident #43 with ADL care deficit. The goal: will have ADL's met daily through next review (09/10/19). Some of the intervention/approaches to manage goal included dressing and grooming with extensive-total assistance of one and provide needed assistance with self-care daily and as needed.

On 07/25/19 at approximately 9:14 a.m., wound care nurse and this surveyor assessed resident's toenails. The nurse removed sock from the resident's right foot with the following observed: the great and second toe was long and thick and cured to the side but the third, fourth and fifth digit was long and had curved overtop the toe with the nail coming in direct contact with her skin." The

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nurse removed the sock from the right foot; second and third toenail was long and had curved overtop the toe with the nail coming in direct contact with her skin."

On 07/25/19 at approximately 9:34 a.m., the Director of Nursing (DON) and this surveyor assessed resident's toenails. The DON said Resident #43's toenails should not look like that; I would not want my toenails to look like that. The DON stated, "Once I got here, I did identify there was an issue with toenails here." The surveyor asked, "Does Resident #43 need podiatry care" she replied, "Yes, very much so." The DON said the podiatrist is scheduled to come today to provide podiatry service. The surveyor asked if Resident #43 was on the podiatry list to be seen. On the same day at approximately 10:22 a.m., the DON stated, "No, Resident #43 is not on the podiatry list. She is now hospice; I will be contacting them today. The surveyor asked, "What is your process for getting resident's toenails cut and trimmed?" She said the Certified Nursing Assistant (CNA) would report to the nurse, the nurse would assess the resident toenails and if they needed to be cut, they nurse will notify me and I will place them on the podiatry list to be seen. The surveyor asked, "When was the last time Resident #43 had podiatry services" she replied, "Back in March 2018."

The Administrator, Director of Nursing and Regional Administrator was informed of the finding during a briefing on 07/26/19 at approximately 5:15 p.m. The facility did not present any further information about the findings.

The facility did not have a policy related to podiatry services or foot care.

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4. Resident #12 was admitted to the facility on 6/6/2016 and readmitted on 7/3/17 with diagnoses that included but were not limited to atrial fibrillation, diabetes, COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/26/19. Resident #12 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

During an interview on 7/24/19 at 2:00 p.m., Resident #12 had expressed concerns that she needed to see podiatry services. Resident #12 stated that the nail to her big toe on her left foot had periods of bleeding. Resident #12 stated that she currently had blood on the side of her toenail. Resident #12 stated that staff did not look at her feet but that they were aware of her need for podiatry. When asked if she had seen the in house podiatrist, Resident #12 stated that she did not want to be seen by the in-house podiatrist because she felt that his wife (an assistant) was rude to her one day. Resident #12 stated that this was a long time ago and could not recall the date. Resident #12 stated that the facility had made three appointments to an outside podiatrist but that transportation had canceled three times and now the outside podiatrist will not accept her. Resident #12 could not recall the dates of when these appointments were made. Resident #12 showed this writer her left foot. Her left big toenail appeared to be ingrown with dried up blood on the side of the nail. Her third toenail was also long and thickened. Resident #12 stated that the staff refuse to cut her toenails because she is diabetic.

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Resident #12 stated that her toenails had been like that for some time.

Review of Resident #12's clinical record failed to evidence her refusal to see the in-house podiatrist and her canceled podiatry appointments due to transportation.

Review of the current podiatry list at the nurses station failed to show her name on that list.

Further review of Resident #12's clinical record revealed she was last seen by the in-house podiatrist on 5/16/18.

Review of Resident #12's latest skin assessment conducted 7/21/19, failed to document her big toenail and thickened third toenail.

On 7/25/19 at 9:30 a.m., an interview was conducted with ASM #2, the ADON (Assistant Director of Nursing) and the interim DON (Director of Nursing). When asked the process for obtaining podiatry services for a resident, ASM #2 stated that they had an in-house podiatrist that will routinely see residents and any new residents that are placed on his list. ASM #2 stated that she keeps a podiatry list on the nursing units and she will add residents as staff tell her who needs podiatry services. When asked how often the in-house podiatrist comes into the facility, ASM #2 stated that she was not sure how often the podiatrist was supposed to come in. ASM #2 was asked to obtain a policy on foot care for this writer. ASM #2 was made aware of Resident #12's left toenails by this writer. ASM #2 stated that this information was new to her. ASM #2 stated that she could not find any recent podiatry notes on Resident #12. ASM #2 was

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asked to grab this writer before she made her own observations of Resident #12's left foot.

On 7/25/19 at 11:01 a.m., further interview was conducted with ASM #2. ASM #2 stated that she did not have a policy on foot care. ASM #2 stated that the podiatrist was supposed to come in every 12 weeks. ASM #2 stated that the podiatrist will put a note in the clinical record every time he sees a resident. When asked if he will document if a resident refuses podiatry care, ASM #2 stated that he will usually document refusals in a note. When asked if there was a way to figure out if a resident sees outside podiatry, ASM #2 stated that the visits with outside podiatry should be scanned into the computer system. When asked if there was a way to see if podiatry appointments were canceled, ASM #2 stated canceled appointments should be documented in a progress note in the resident's clinical record. ASM #2 was asked to find any evidence that Resident #12 was set up with outside podiatry and any appointments canceled.

On 7/25/19 at 12:10 p.m., an interview was conducted with the unit manager LPN (Licensed Practical Nurse) #1. When asked if Resident #12 ever had concerns or complaints regarding her toes, LPN #1 stated, "She complains about everything, she has every disease." LPN #1 also stated that Resident #12 was a hypochondriac. When asked how often skin checks were performed on residents, LPN # 1 stated that skin checks should be completed every three day and the CNAs (certified nursing assistants) should be performing skin checks every day with bathing. When asked if staff assist Resident #12 with bathing, LPN #1 stated that staff only set her up and she can do the rest herself. LPN #1 was

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made aware by this writer about Resident #12's toes. LPN #1 stated that she was never made aware that Resident #12 needed to see podiatry. When asked if toes was something that should be checked during a skin assessment by nursing staff, LPN #1 stated that nurses should be checking toes as well as the skin during the skin assessment. When asked if the condition of toes should be documented if there is a concern, LPN #1 stated that it should be documented in the clinical record. LPN #1 confirmed that Resident #12 was not on the recent podiatry list.

On 7/25/19 at 4:13 p.m., an interview was conducted with ASM #4, the podiatrist. ASM #4 stated that each resident on his list will be seen once every three months to cut toenails or sooner if a resident is having an issue with their feet. When asked if he knew the last time he saw Resident #12, ASM #4 stated that he thought she was one of his regular people but that she was not on his list to be seen that day. ASM #4 stated that sometimes residents will fall off his list if their insurance changes. ASM #4 stated that he does not see residents if there primary insurance is Optima. ASM #4 was shown that Resident #12's insurance was never Optima. ASM #4 stated that he was not sure what was going on. When asked how he was made aware of residents that need to be seen for podiatry services, ASM #4 stated that the facility will hand him a list of his regular patients and any new patients that need to be seen. ASM #4 stated that this list is updated by the facility. ASM #4 was made aware of Resident #12's left toenails by this writer. ASM #4 stated, "I can go see her if you want me to." ASM #4 was informed that this writer could not make that decision.

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F 687	Continued From page 54 On 7/25/19 at 5:15 p.m., a second observation was made of Resident #12's left toenails with ASM #2. ASM #2 confirmed this writer's observations. ASM #2 was asked again to provide any documentation of Resident #12's missed podiatry appointments with the outside podiatrist. On 7/26/19 at 5:53 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the administrator and ASM #2 the ADON and interim DON. No further information was presented prior to exit.	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility staff failed to provide adequate supervision and failed to ensure heated beverage was served in a manner to prevent an avoidable accident for 1 of 59 residents in the survey sample (Resident #83), with known behaviors of throwing objects, food and beverages resulting in harm, a second degree burn, to Resident #74. The staff served Resident #83 a cup of hot coffee without a lid. Resident #83 threw the hot coffee onto Resident #74 resulting in a second degree burn to the resident's left upper thigh requiring	F 689	1. Resident #83 has a cup with an attached lid for all hot beverages. Care plan and care guides updated for resident #83 to address use of cup with an attached lid for hot beverages. 2. Audit of current residents with behaviors, cognitive loss, and decreased ability to hold a cup to identify other residents at risk. 3a. Education by DON or designee with nursing staff on ensuring resident #83 has a sturdy cup with a lid.	8/26/19

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F 689	Continued From page 55 physician intervention, medication and treatment. A second degree burn involves the first two layers of the skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin. Referenced from http://www.bt.cdc.gov/masscasualties/burns.asp The findings include: A Facility Reportable Incident (FRI), incident type Unusual Occurrence, was received at the State Agency on 1/23/19. The FRI evidenced that on 1/22/19, Resident #74 while in her wheelchair bumped into the wheelchair of Resident #83. This resulted in Resident #83 "throwing her coffee" at Resident #74. The hot coffee caused a second degree burn to Resident #74's left upper thigh. 1a. Resident #74 was admitted to the facility on 4/27/16 with diagnoses to include, but not limited to a stroke resulting in paralysis of the right upper and right lower extremities and anoxic (absence of oxygen) brain damage. The MDS (Minimum Data Set) prior to the unusual occurrence incident was a quarterly with an Assessment Reference Date of 11/21/18. The resident scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired decision making skills. Resident #74 was wheelchair bound. The Nursing Noted dated 1/22/19 written by the nurse who heated the hot water in the microwave to make the coffee and served it without a lid to Resident #83 read as follows: "Patient sitting at	F 689	3b. Education by Dietary Manager for dietary staff on ensuring resident #83 has a sturdy cup with a lid. 3c. Nursing staff will be educated to provide covered lid cup for all hot beverages. 3d. The facility will add a lid to all coffee cups served to residents to decrease risk for spillage unless resident declines use. 4a. Audit by DON 5 times a week x 12 weeks to ensure that resident #83 has special sturdy cup with attached lid for hot beverages. 4b. Audit to be conducted by dietary manager 5 times a week x 12 weeks for all meals to ensure cups with hot beverages have a secured lid prior to leaving the kitchen. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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nurses station at 1830 (6:30 p.m.) with a cup of hot coffee and another resident (Resident #74) in a W/C (wheelchair) was passing by and bumped into her and (Resident #83) threw her cup of coffee at the resident and it landed on her lap."

The Nurse Practitioner note dated 1/23/19 evidenced the following documentation:"...Today, was called by nursing to assess new skin concern noted to left upper thigh area. The area is raised, erythematous (red) and swollen. Two blisters are noted and intact. Wound nurse consulted. After further information obtained from staff, it was noted that another resident spilled coffee on (Resident #74) and this is the cause of the blistering..." AP (Action/Plan): Left leg cellulitis/burn: Started on Keflex (an antibiotic) 250 (mg-milligrams) QID (four times a day) x 7 days, consulted with the wound nurse. Will add Silvadene ointment and xarafoam dressing to protect site. Will follow up in 48-72 hours.

The wound nurse assessment dated 1/23/19 evidenced the following documentation: 1. Wound type-Burn. 2. Wound location- left upper thigh. The wound measured 2 cm (centimeters) length x 6 cm width and 0.1 cm depth. Small amount of drainage, wound bed pink in appearance, periwound (surrounding skin) pink. Pain level: 4. The Weekly Wound Assessment dated 1/28/19 evidenced the burn wound measured 1.6 cm x 3.0 cm x 0.1 cm, scant drainage, periwound pink. The Weekly Wound Assessment dated 2/4/19 evidenced the burn area had resolved.

1b. Resident #83 was admitted to the facility on 10/16/17 with diagnoses to include, but not limited to schizophrenia, bipolar disorder, Alzheimer's disease and combative behaviors. The MDS

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(Minimum Data Set) prior to the unusual occurrence incident on 1/22/19 was a quarterly with an assessment reference date of 12/8/18. The resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderately impaired daily decision making skills. The resident exhibited hallucinations, delusions and behaviors of rejecting care.

Review of the clinical record evidenced Resident #83 had a history of known behaviors that had a potential to cause injury towards staff and other residents. The documented behaviors included: 4/28/18 while in the hallway the resident attempted to take the purse of another resident, when the other resident picked up the purse so that Resident #83 could not get it Resident #83 threw a magazine toward her; 5/20/18 threw ice while in the hallway, 5/23/18 threw things on her floor, 6/24/18 combative, throwing things at resident's family members as they were coming through the door, 7/1/18 threw a cup of water at a C.N.A. (certified nurse assistant) walking by her, threw a plate cover while at the nurses station towards a nurse, 7/13/18 while at the nurses station hit another resident in the chest.

The Comprehensive Person-Centered Care Plan dated 11/2/17 identified a focus care area of mood and behaviors related to diagnoses of schizophrenia, bipolar, psychosis and dementia with behaviors. Identified behaviors included but were not limited to, throwing objects, throwing lunch and dinner trays, combativeness and impulsive behaviors. The care plan did not include interventions during meal times prior to the incident to prevent potential avoidable accidents of the resident throwing lunch and/or

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dinner trays, food and or beverages.

The last psychiatric evaluation/consult was dated 1/9/18. The resident's mood was described as "labile and combative at times." Insight and judgement were poor.
(Labile/lability-excessive emotional reactivity associated with frequent changes or swings in emotions and mood referenced from Tabers Cyclopedic Medical Dictionary 19th Edition.)

The five day facility follow up report to the FRI was received at the State Agency on 1/28/19. The report read in part:"...The nurse on the unit made the coffee. She heated the water in the microwave for 1 minute and then added instant coffee and thickener. The facility replicated the making of the coffee; same type of cup, same amount of time and the temperature after heating was 124 degrees (Fahrenheit)... The facility will provide a sturdy cup with a lid for (Resident #83's name)...Care plans were updated on both residents..."
There is no evidence in the facility's report that the nurse obtained the hot beverage temperature at the point of service prior to serving the coffee.

Table 1. Time and Temperatures Relationship to Serious Burns-Time Required for a 3rd Degree Burn to Occur at 124 degrees Fahrenheit is 3 minutes. Referenced from http://www.bt.cdc.gov/masscasualties/burns.asp

On 7/25/19 the Comprehensive Person-Centered Care Plan dated 11/2/17 was reviewed for a second time and did not include the revision/ implementation of a sturdy cup per the five day follow up report. The care plan was revised on 1/22/19, the intervention was to educate staff and

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visitors that resident is not to receive hot beverages. On 7/26/19 at 5:53 p.m., the MDS Coordinator who revised the care plan on 1/22/19 was interviewed. She stated she failed to completely revise the intervention which should have read, "Educate staff that resident is not to receive hot beverages unless it is in a cup with a secure lid". When asked if that was an important piece to have been left off the intervention she stated, "Yes ma'am it sure was".

On 07/25/19 at 11:48 AM, the resident's lunch tray was observed placed on top of the bedside drawer instead of the bedside table. A CNA approached the resident to inform her of the delivery of the tray. A mug of coffee was observed on the tray with a unsecured plastic cover. The resident removed the plastic lid and drank her coffee from the mug. The CNA did not place the coffee into the sturdy cup. 07/25/19 at 05:29 PM, the resident was asleep in a wheelchair in front of nurses station. The resident's dinner tray was delivered to the resident room. The tray was observed to have coffee and water as beverages. The CNA who delivered the tray left the coffee inside the coffee mug with an unsecured plastic lid instead of transferring it into the sturdy cup. The resident then wheeled herself slowly into her room and began to consume her dinner and drink her coffee from the mug. Observed on the bedside table was a black 14-16 ounce sturdy cup with a secure lid (travel mug) for use.

On 7/25/19 at 5:45 p.m., Licensed Practical Nurse #3 and #4 were interviewed. LPN #3 stated, "When I first got here she (Resident #83) was eating at the nurses station, she would have outbursts and push her trays onto the floor...this

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is why she now gets served in her room." When asked when was the last time the resident exhibited this behavior; LPN #3 stated, "About 4-5 weeks ago." LPN#4, assigned to care for Resident #83 was asked if the resident was allowed to have hot beverages per the care plan. LPN #4 stated, "I don't know, I am going to look that up." LPN #4 also stated the resident had coffee for all meals.

On 7/26/19 at 10:58 am, the above findings was shared with the Administrator and the Interim Director of Nursing (DON). The Administrator provided this surveyor with a Corrective Action Plan in response to the unusual occurrence. The Administrator stated, "We knew about her behaviors, combative with staff, throwing objects, throwing lunch and dinner trays...She has never been aggressive with other residents...it wasn't an issue with the temperature (the hot coffee), it was her behaviors..." The DON stated the resident was, "...very impulsive, she'll be quite and then she reacts according to what she hears in her head..." They stated a thermometer to temp food and beverages was placed in the nourishment room, staff were educated, the resident was provided a sturdy cup with a lid for hot beverages, the resident was encouraged to eat at the nurses station to provide supervision, the DON stated, "That's why we liked her at the nurses station" and microwave heating instructions was added as part of general orientation. When asked if there was anything that could have been done differently to prevent this occurrence, the DON stated, "The nurse not turn her back (after serving the resident hot coffee) and give her a lid (for the coffee)."

Review of the facility policy titled "Hot Beverage

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F 689	Continued From page 61 Service" effective date October 22, 2018 reads as follows: Policy: Facility will provide hot beverages to residents in a manner that promotes safety and meal satisfaction. Procedure: 4. Appropriate supervision will be provided as needed for residents with decreased safety awareness and/or self-feeding deficits that could place them at risk for burns/scalds 5. Staff will monitor for increased behaviors or agitation at meals and consider an alternative for hot beverages if a resident is at increased risk of burning themselves or others. 6. Staff will monitor hot beverage temperatures periodically at the point of service and make adjustments as needed. An inspection of the facility's one nourishment room was conducted on 7/26/19 at approximately 5:00 p.m., there was a sign posted above the microwave for the staff that read: Attention Staff-When heating liquids for consumption the temperature should never exceed 155 degrees. Please obtain temperature before serving and do not serve if over 155 degrees. Please sanitize thermometer before and after use. A thermometer was observed stored inside a plastic bag on top of the microwave.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		8/26/19

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F 695	Continued From page 62 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation, and clinical record review, it was determined that facility staff failed to maintain respiratory equipment in a sanitary manner for two of 59 residents in the survey sample (Residents #31 and #89); and failed to administer oxygen per physician's order for Resident #31. 1. Resident #31 was admitted to the facility on 2/4/16 with diagnoses that included but were not limited to pneumonia, muscle weakness, and Alzheimer's disease. Resident #31's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with and ARD (assessment reference date) of 5/10/19. Resident #31 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #31's clinical record revealed that he was diagnosed with pneumonia on 7/20/19. The following orders were documented: 1) 02 (oxygen) continuous via NC (nasal cannula) at 2 L (liters)/min (minute) every shift. 2) Levofloxacin Tablet (Levaquin-an antibiotic) (1) Give 750 mg (milligrams) by mouth one time a day for infiltrated lower left lobe until 7/27/19." On 7/25/19 at 11:18 a.m., an observation was made of Resident #31. Resident #31 was observed in his high back wheelchair with his oxygen not in place. His oxygen concentrator was on with his oxygen tubing on top of his sheets on his bed. The nasal cannula part of the tubing was	F 695	1. The filter on the oxygen concentrator for resident #89 was cleaned on 7/26/19. The nasal cannula was replaced for resident #31 on 7/26/19. 2. Audit of all current residents receiving oxygen to ensure nasal cannula, oxygen tubing, and oxygen concentrator filters are cleaned to identify other residents at risk. 3. Education by Unit Managers or designee with nursing staff on proper placement of nasal cannula during resident care and following facility's protocol regarding cleaning oxygen filters. 4. Audit by Unit Manager 5 times a week x 12 weeks on residents receiving oxygen therapy to ensure oxygen filters are being cleaned according to facility protocol as well as monitoring facility's staff to ensure proper nasal cannula placement during resident care. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19.	

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wedged in-between his mattress and head board of the bed. Resident #31's sheets were visibly soiled. On 11:20 a.m., Resident #31's nursing assistant was observed to take the oxygen tubing off the bed and drape it over Resident #31's over bed table. Resident #31's oxygen tubing remained draped across the over bed table until 11:32 a.m. At 11:32 a.m., Resident #31's nursing assistant was observed placing the same oxygen tubing/cannula that was on top of his bed into Resident #31's nose. Resident #31 was also observed to be without oxygen for a total of 14 minutes.

On 7/25/19 at 11: 53 a.m., the CNA (certified nursing assistant) #3 was asked, if Resident #31's oxygen tubing was the same tubing that was on his bed. CNA #3 stated that it was the same tubing. When asked if it was okay to put the same tubing that was on the residents dirty sheets into the resident's nose, CNA #3 stated that the nasal cannula piece was not on the bed. When told CNA #3 about the above observations, she denied the tubing and nasal cannula was on Resident #31's bed, that she had draped the oxygen tubing across his bedside table when she got him out of bed. CNA #3 stated that she knew not to put contaminated tubing on a resident.

On 7/25/19 at 11:45 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #4, Resident #31's nurse. When asked what continuous oxygen meant, LPN #4 stated that continuous oxygen meant that oxygen should be on at all times. When asked if it was okay for a resident with an order for continuous oxygen to be off oxygen for over 10 minutes, LPN #4 stated that it was not okay. When asked if Resident #31 was on continuous oxygen, LPN #4 stated that he

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was recently placed on continuous oxygen due to a upper respiratory infection (URI) and had periods of oxygen desaturation. LPN #4 also stated that Resident #31 was on an antibiotic for his URI. When asked if it was okay to put contaminated oxygen tubing back on a resident when it was wedged between the bed and headboard, LPN #4 stated that it wasn't okay, that new tubing should be placed. LPN #4 stated that contaminated tubing was an infection control issue.

On 7/26/19 at 5:53 p.m., the above concerns were addressed with ASM (administrative staff member) #1, the Administrator and ASM #2 the ADON and interim DON.

No further information was presented prior to exit.

2. Resident # 89 was initially admitted to the facility on 12/28/18 with diagnoses to include but not limited to Congestive Heart Failure and Chronic Respiratory Failure.

The most recent Minimum Data Set (MDS) is a Quarterly with an Assessment Reference Date of 7/2/19. Under Section B Hearing, Speech and Vision Resident #89 is coded Comatose Under B0100. Under Section O Special Treatments, Procedures, and Programs Resident #89 as receiving Oxygen Therapy.

Resident #89's Comprehensive Care Plan last revised 7/9/19 was reviewed and is documented in part, as follows:

CARDIORESPIRATORY STATUS: Name (Resident #89) receives O2 (oxygen) via nasal cannula related to CHF (Congestive Heart

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Failure) and chronic respiratory failure.
Date Initiated: 4/5/19
Revision on: 7/4/19

Goal: The resident will have no signs or symptoms of poor oxygen absorption through the next review date.

Resident #89's Order Summary Report dated July 2018 was reviewed and is documented in part, as follows:

Clean O2 filter/screen on concentrator daily, every night shift related to chronic respiratory failure. Order Date: 6/6/19 Start Date: 6/6/19

Resident #89's Medication Administration Record (MAR) Dated 7/1/19 through 7/31/19 was reviewed and is documented in part, as follows:

Order: Clean O2 filter/screen on concentrator daily, every night shift related to chronic respiratory failure. The order was signed off as being completed every night (11-7) from 7/1/19 through 7/25/19.

The following observations were made of Resident #89's oxygen concentrator filter while on survey.

07/24/19 02:45 PM O2 (oxygen) via NC(nasal cannula) and concentrator at 4 lpm (liters per minute). O2 concentrator filter dirty covered in a thick light gray dust.
07/25/19 11:59 AM O2 via NC and concentrator at 2 lpm. O2 concentrator filter dirty remains covered in a thick light gray dust.
07/25/19 03:25 PM O2 via NC and concentrator at 2 lpm. O2 concentrator filter dirty remains

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F 695	Continued From page 66 covered in a thick light gray dust. On 7/26/19 at approximately 9:45 A.M. the Administrator was asked when the facility oxygen concentrator filters are cleaned. The Administrator stated, "They are cleaned once a week by the 11-7 shift, we don't replace them they are washed out and put back in the concentrator." The Administrator was asked to walk with the surveyor to Resident #89's room to inspect the oxygen concentrator filter that was signed off as being cleaned every night. The Administrator stated, "It gets cleaned once a week. I'm not sure which night she is scheduled to have it cleaned I will have to check." The Administrator was showed the Resident #89's MAR that showed the order for the filter to be cleaned every night and the staff signatures that the filter was cleaned. The Administrator stated, "This has not been cleaned." The facility had no policy for cleaning the oxygen concentrator filters. On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared. Prior to exit no further information was shared.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		8/26/19

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F 698	Continued From page 67 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident record review, staff interviews and facility document review the facility staff failed to ensure an ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 59 resident in the survey sample, Resident #73. The findings included: Resident #73 was a 70 year old admitted to the facility on 12/7/18 with diagnoses to include but not limited to End Stage Renal Disease and Type II Diabetes Mellitus. The most recent Minimum Data Set (MDS) is a Quarterly assessment with a Assessment Reference Date (ARD) of 6/21/19. The Brief Interview for Mental Status (BIMS) for Resident #73 was a 10 out of a possible 15 indicating the resident had mild cognitive impairment but was capable of some daily decision making. Under Section O Special Treatment, Procedures, and Programs Resident #73 was coded as receiving Dialysis Services. Resident #73's current Physician Orders were reviewed and are documented in part, as follows: May attend dialysis on Monday, Wednesday, and Friday. Resident #73's Comprehensive Care Plan dated 7/2/19 was reviewed and is documented in part, as follows:	F 698	1. New communication book provided for resident #73 for dialysis. 2. Audit of current residents receiving dialysis to ensure dialysis communication book is available and in use to identify other residents at risk. 3. Education by Unit Manager or designee with licensed nursing staff to include order and use of communication book. 4. Audit by DON 5 times a week x 12 weeks for residents receiving dialysis to ensure communication books are being utilized. Audit results will be taken to QAPI for review and revision as needed. 5. 08/26/19	

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Dialysis: (Resident #73's Name) receives dialysis related to ESRD (end stage renal disease) on Monday, Wednesday and Friday.
Date Initiated: 12/19/18

On 07/25/19 at 10:28 AM Resident #73 was observed lying in bed and had just eaten breakfast. Resident #73 was asked if she is a dialysis patient. Resident #73 stated, "Yes, I go to dialysis on Mondays, Wednesdays, and Fridays. I went yesterday."

On 07/25/19 at 10:45 AM Unit Manager LPN (Licensed Practical Nurse) #1 was asked for the Resident#73's Dialysis Communication Book/Log. The Unit Manager LPN #1 was unable to find the Resident's dialysis communication book/log at the nurse's station or in the Resident's room. The Unit Manager LPN #1 called the Dialysis Center to see if the communication book was left there yesterday, which it was not. The Unit Manager LPN #1 was asked when was the last time she had seen the Resident's dialysis communication book. The Unit Manager stated, "I haven't seen it for a few weeks. I guess I need to make her a new one."

On 7/26/19 at approximately 10:15 A.M. the Director of Nursing was asked if dialysis residents should have an ongoing form of communication between the facility and the dialysis center and if she was aware that Resident #73's dialysis communication book was missing. The Director of Nursing stated, "Yes each dialysis resident has a book that goes with them to the dialysis center on their dialysis days. We record the vitals and the dialysis center sends it back with the pre and post dialysis weights, vitals and any medical information about the resident that may have

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occurred during their treatment there. I was not aware that we were missing hers, they need to call the dialysis center." The Director of Nursing was made aware that Unit Manager LPN #1 called the dialysis center yesterday to try to located Resident #73's Dialysis Communication Book.

The Facility Policy titled "Hemodialysis Care Policy" effective 6/16/17 was reviewed and is documented in part, as follows:

Documentation:

The nurse should document in the resident's record shift:
4. Any part of follow up needed from report from dialysis nurse post-dialysis being given.
Plan of Care Protocol:
-Pre and post dialysis weight for every visit provided by dialysis center;
-Monitor lab values provided by dialysis center and any other labs completed.

Most problems that arise with hemodialysis occur during dialysis or immediately afterwards. Communicate any negative findings with the attending physician and the dialysis center. The dialysis clinic will be responsible for providing the facility with the needed documentation to care for the patient.

On 7/26/19 at approximately 5:15 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Administrator where the above information was shared. Prior to exit no further information was shared.

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F 812	Continued From page 70	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure food was labeled and dated in the kitchen refrigerator. The findings included: During the initial tour of the Kitchen on 07/24/19 at approximately 11:00 a.m. the following were observed in the kitchen refrigerator: 1. One small container of beets- with initials DR (staff member initials). 2. Dietary staff lunch box found in refrigerator.	F 812	1. Personal lunch box was removed from the refrigerator immediately and all food items cited were labeled or discarded appropriately. 2. Audit of refrigerator including walk in refrigerator to ensure all items were labeled and no personal food items are stored in the refrigerator to identify additional issues. 3. Education by Dietary Manager or designee with dietary staff on labeling of all opened food items and also not to store personal lunch boxes in refrigerator. 4. Audit by Dietary Manager 5 times a week x 12 weeks of refrigerator including	8/26/19

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F 812	Continued From page 71 3. One 15 pound pork not labeled or dated. 4. One container of Moderately Thicken Sweet Tea exp. 1/15/20 was opened with no open date written on container. 5. One container of Mildly Thicken Sweet teas exp. 11/05/19. was opened with no date written on container. On 07/24/19 at 3:50 PM a brief interview was conducted with the Regional Dietitian, (Other Staff #3) and Dietary Cook (Other Staff #10) concerning the above findings. They were asked what should have been done. Other Staff #10, stated "I should have labeled and put the dates on opened containers." On 07/26/19 at approximately,5:35 PM, a pre-exit interview was conducted. Present were the Assistant Director Of Nursing (ADON), Administrative/Corporate Staff #3 and the facility Administrator. No comments were made concerning the above.	F 812	walk in refrigerator in the kitchen to ensure all open food items are labeled and no personal lunch boxes are stored in the kitchen's refrigerator. Audit results will be taken to QAPI for review and revision as needed. 5. 08/26/19	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/26/19

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F 880	Continued From page 72 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 73 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, it was determined that facility staff failed to ensure annual review of the antibiotic stewardship and infection control policies; and failed to ensure staff wear the appropriate PPE (Personal Protective Equipment) for contact precautions for one of 59 residents in the survey sample, Resident #12. The findings included: 1. On 07/26/2019 at approximately 1:30 p.m., the Surveyor met with the Assistant Director of Nursing (ADON) to review the facility's Infection Prevention and Control Program. The Surveyor requested a copy of the Infection Prevention and Control Program Policy. On 07/26/2019 at approximately 5:00 p.m., the ADON provided a copy of the, "Infection Control Policy" dated with an effective date of May 2015 to the Surveyor. The Surveyor asked the ADON if she could provide a copy of the facility's "Infection Prevention Control Program Policy"	F 880	1. Facility's Infection Control Policy was reviewed on 7/26/19. Personal Protective Equipment (PPE) available at resident's #12 door. 2. Audit of current residents on precautions to identify others at risk. 3. Education by DON or designee with nursing staff on Infection Control Policy including use of PPE. 4. Audit by Unit Manager 5 times a week x 12 weeks to ensure staff is adhering to facility's infection control standards and following company's policy related to PPE. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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which was provided and dated with an effective date of April 16, 2018.

There were no documented dates on the policy indicating when the policy was reviewed or revised. The surveyor requested a sign in sheet of the committee members who may have reviewed and/or revised the policy annually. The ADON stated, "Corporate reviews and revises the policies. All policies come through corporate. We only have it in "Read Only" here at the facility." The ADON was asked, "Does the facility have a more recent copy of the Infection Prevention and Control Program Policy as this one is dated April 16, 2018 and does not have a review date." The ADON stated, "This is all I could find."

The Administrator, Assistant Director of Nursing and Regional Administration was made aware of the findings at the pre-exit meeting on 07/26/2019 at 5:20 p.m. No further information was provided about the findings.

2. For Resident #12, facility staff failed to maintain infection control practices and wear the appropriate personal protective equipment (PPE); and failed to dispose contaminated gloves appropriately while she was on contact precautions for MRSA (Methicillin-resistant Staphylococcus aureus) in the urine.

Resident #12 was admitted to the facility on 6/6/2016 and readmitted on 7/3/17 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease) and MRSA (methicillin-resistant Staphylococcus aureus) of the urine (1). Resident #12's most recent MDS

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(Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/26/19. Resident #12 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #12's July 2019 POS (physician order summary) revealed that she was placed in contact precautions on 7/18/19. The following order was documented: "Place on contact Precautions for MRSA one time a day for Precautions."

On 7/24/19 at 2:15 p.m., an interview was conducted with Resident #12. Resident #12 stated that that day (7/24/19) was the first time staff were wearing the PPE (personal protective equipment). Resident #12 stated that she was aware she had MRSA in the urine on 7/18/19.

On 7/25/19 at 12:26 p.m., an observation was made of LPN (Licensed Practical Nurse) #2. LPN #2 was observed to put on gloves and walk into Resident #12's room with a urine hat (2). LPN #2 placed the hat in the toilet, removed her gloves and had them crumpled up in her hand on her way out of Resident #12's door. LPN #2 then walked to the bathroom behind the nurses station, threw out the gloves and washed her hands. LPN #2 failed to wear a gown upon entering Resident #12's room and failed to dispose of gloves and wash her hands prior to leaving Resident #12's room.

On 7/26/19 at 9:49 a.m., an interview was conducted with LPN #2. When asked why Resident #12 was on contact precautions, LPN #2 stated that Resident #12 had MRSA in her

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urine. When asked what type of PPE she should wear prior to entering Resident #12's room, LPN #2 stated that she would put on a gown and gloves. When asked why she should wear a gown and gloves, LPN #2 stated that she should wear a gown and gloves in case she comes into contact with the resident or brushes up against a contaminated surface. When asked when the gown and gloves should be removed, LPN #2 stated that they should be removed prior to leaving the room. LPN #2 was told about the above observations. LPN #2 stated she "Should have put on a gown prior to entering Resident #12's room because she was in close proximity to the toilet." LPN #2 stated that she had a second pair of gloves that were in her hand on her way out the door. LPN #2 stated they were not the same gloves she used to place the hat in the toilet. This writer did not make an observation of LPN #2 throwing the first pair of gloves away and grabbing a second pair of gloves.

On 7/26/19 at 5:53 p.m., ASM (administrative staff member) #1, the Administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Infection Control," documents in part, the following: "Contact precautions- intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient's or patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment recommended:

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F 880	Continued From page 77 a. Gloves-whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. b. Gowns-whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident." (1) MRSA (methicillin-resistant Staphylococcus aureus) causes a staph infection that is resistant to several common antibiotics. There are two types of infection. Hospital-associated MRSA happens to people in health care settings. Community-associated MRSA happens to people who have close skin-to-skin contact with others, such as athletes involved in football and wrestling. This information was obtained from The National Institutes of Health. https://medlineplus.gov/mrsa.html.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, documentation review, and complaint investigation, it was determined that facility staff failed to maintain an effective pest control program as evidenced by insects, including roaches and ants, in the kitchen, resident rooms and hallways. The findings Included: 1. The facility staff failed to store, prepare and	F 925	1. Multiple pest control companies contacted 7/26/19 to obtain treatment services. 2. 100% audit of resident's rooms, service areas, kitchen, halls for cleanliness/pests and issues noted were corrected immediately to identify other residents at risk for this issue. 3a. Education by Administrator for Housekeeping Director on cleaning of resident's rooms, common areas, and	8/26/19

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F 925	Continued From page 78 serve food in an insect free environment. On 07/24/19, at approximately 11:00 AM during the initial inspection of the kitchen, the dietary staff were asked if they had "roaches" in the kitchen. Dietary Staff #10, stated "Yes." No live cock roaches were seen in the kitchen by surveyor. On 07/25/19, day 2 of the kitchen inspection, at approximately 11:00 AM., while inspecting the dry storage area, seven (7) dead cockroaches were seen on the floor located underneath the shelving in the dry storage area. The Regional Dietician (Other Staff #13) was present. She confirmed that they were dead cockroaches. A review of the Sanitation/Inspection and Service report read the following: Dated 6/18/18 dead water bugs under the kitchen sink. Dated 2/4/19 checked and treated room 307 and 309. Log book noted roaches. No activity found. Kitchen-Dead exterior roaches. Dated 6/03/19 Reads reads Interior areas such as lobby/public areas, entryways, guest rooms etc. Pests (2) (American Cockroaches). Food areas-serving line,salad bar, dining area, stove/oven line, waiters station,food storeroom, dishwashing, deli/bakery, kitchen, processing area, packaging area, produce area and meat/seafood shop- (2) American cockroaches. Exterior areas-Perimeter, patio/deck, dumpster, windows,doors,walls. On 07/26/19 at approximately,12:46 PM a letter was received from maintenance staff (Other Staff #11 and Other Staff #12). It read the following: Please be advised that a local Pest Control	F 925	follow up. 3b. Education by Housekeeping Director for housekeeping staff on maintaining all resident's room, common areas clean and as well as stored residents and staff open food items and containers. 3c. Education by Dietary Manager for dietary staff on cleaning kitchen and reporting any pests observed. 4a. Random audits of 4 rooms per hallway by Housekeeping Director of resident's room and common areas 5 times a week x 12 weeks. 4b. Audit 5 times a week x 12 weeks of the kitchen by dietary manager. Audit results will be taken to QAPI for review and revision as needed. 5. 8/26/19	

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Company has a scheduled appointment with said facility with the Maintenance Supervisor (Other staff #11) on July 29th @ 9 AM to discuss additional general pest control treatments to the interior rooms.

On 07/26/19 12:51 PM the Maintenance Supervisor (Other Staff #11) stated that the facility is being treated weekly by local pest control.

On 07/26/19 at approximately 5:35 PM a Pre-exit interview was held with the Assistant Director of Nursing(ADON),Corporate/Administration staff #3 and the facility Administrator #1. The facility Administrator stated that they are "Reaching out to a different pest control company."

2. Resident #12 was admitted to the facility on 6/6/2016 and readmitted on 7/3/17 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/26/19. Resident #12 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 7/24/19 at 2:00 p.m., an interview was conducted with Resident #12. Resident #12 had stated that she was afraid of the roaches that were in her room. Resident #12 stated that she liked to leave her bathroom light on during the night to prevent the roaches from coming into her room. Resident #12 also stated that the bathroom light helped her see around to make sure roaches were not on her bed. Resident #12 stated that on one occasion she was woken up due to a roach crawling on her. During this interview a large

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roach was observed crawling out from underneath her wheelchair. Resident #12 told this writer to kill it so she didn't have to worry about the location of the roach later. Resident #12 stated, "This is what I am talking about." Resident #12 stated that she sees people spray for bugs in the hallway but that no one has ever been in her room to spray. Resident #12 stated that she didn't have enough money to have someone buy bug spray for her.

Concerns regarding roaches and an ineffective pest control program were discussed with the maintenance department.

On 7/26/19 at 5:53 p.m., these concerns were expressed with ASM (administrative staff member) #1, the Administrator. When asked if roaches in residents rooms was a clean, comfortable and homelike environment, ASM #1 agreed that it was not.

No further information was presented prior to exit.

3. The facility staff failed to maintain pest control in Resident #410's room. Resident #410 was originally admitted to the facility on 11/05/18. Diagnoses included but not limited to End Stage Renal Disease and Dependence on Renal Dialysis.

The current Minimum Data Set (MDS) a discharge assessment MDS with an Assessment Reference Date (ARD) of 11/05/18. The Brief Interview for Mental Status (BIMS) was not conducted.

The facility staff failed to maintain an effective pest control program. Review of the pest sighting

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logs from 03/25/19 through 07/22/19 revealed the following sightings on the West Unit: roaches seen in the following areas: resident rooms, on the resident bed, in the hallways and at the nurse's station. Ants were seen in the following areas: in the residents room around the windows, under the sink in the medication room and a mouse seen chewing through bags in the top of a resident's drawer.

Review of the pest sighting logs from 02/25/19 through 07/07/19 revealed the following sightings on the East Unit: roaches seen in the following areas: under the resident's bed, in the resident's bathroom, on the walls in the resident room and in the resident night stand. Ants were seen in the following areas: resident rooms in the windows, skin and nightstand and in the air conditioning unit in the resident rooms.

On 07/25/19, an interview was conducted with the Administrator at approximately 2:03 p.m. She stated, "We do have an issue with bugs/roaches in the building but we are doing our best to handle the problem." She said a pest control company comes out on a regular basis to spray and more often if needed.

An interview was conducted with Certified Nursing Assistant (CNA) #4 on 07/25/19 at approximately 2:17 p.m. She said there is a real problem with water bugs/roaches but I never see one on a resident. She said if an insect is spotted we are to write the pest sighting in the log book at the nurse's station.

On 07/26/19 at approximately 11:18 a.m., an interview was conducted with housekeeping staff. He stated, "When I come in during the morning

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hours, I will usually see one or two roaches crawling around in the hallways." He said after pest control sprays, the water bugs/roaches were found dead up in the corners in the hallway and the residents rooms. He stated, "I have never seen bugs/roaches/ants or any type of insect on a resident or on their bed.

An interview was conducted with Manager of Environment on 07/26/19 at approximately 12:02 p.m. He said roaches have been seen in the hallway and in the resident's room. The surveyor asked, "How often do you see roaches in the hallway and in the resident's room" he replied, "Daily." He said they are usually alive until pest control comes out to spray and after that, they are found dead in the door jams and resident rooms. He stated, "A pest control company comes out every 1-2 weeks but we have a different company scheduled to come out; we are trying a different (a more aggressive approach)." He said the pest sighting varies depending on the season but we are trying our best to get the situation under control.

Complaint deficiency.